

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08022

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08008

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN Tb <b>D.O.B.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>			d. STREET ADDRESS <b>241 West High Street</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>LONNIE SANFORD ALLEN</b>			4. DATE OF DEATH Month Day Year <b>June 5, 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-19</b>		9. AGE (In years lost birthday) <b>47 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>		11. BIRTHPLACE (State or foreign country) <b>SPICE, WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>GAILEY ALLEN</b>		
14. MOTHER'S MAIDEN NAME <b>ANNA HANNA</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW2</b>		
16. SOCIAL SECURITY NO. <b>234-12-5480</b>			17. INFORMANT <b>TEXAS H. ALLEN</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO (b) <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of Liver</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>			22. DATE SIGNED <b>6/6/67</b>		
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>			22. DATE SIGNED <b>6/6/67</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-9-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CLIPIN MAJOR MEX. PK.</b>		23d. LOCATION (City or Town) (County) (State) <b>ELKTON, CECIL MD</b>
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>			25a. REC'D BY REGISTRAR <b>ELKTON, MD</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			25c. DATE <b>JUN 8 1967</b>		

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08023

## CERTIFICATE OF DEATH

08009

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN TB 9 Yrs 8 Mo.		d. STREET ADDRESS 348 11th Street, S.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last McKINLEY J ANDERSON		4. DATE OF DEATH Month Day Year June 10 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-98
9. AGE (In years last birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John I. Anderson		14. MOTHER'S MAIDEN NAME Lilla Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 577-28-2335	
17. INFORMANT VA Hospital records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the deceased</del> (this hospital) attended the deceased from Sept. 30, 19 57, to June 10, 1967, and that death occurred on 6:50 PM, from causes on and on the date stated above.			
22a. SIGNATURE BENJ. ROTHFELD		22b. DATE SIGNED 6 11 67	
22c. PHYSICIAN'S NAME (Type) BENJ. ROTHFELD, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-15-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat	23d. LOCATION (City or town) (County) (State) Arlington Va
24. FUNERAL DIRECTOR Henry S. Washington Funeral Home, Wash., DC		25a. REC'D BY REGISTRAR JUN 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08024

CERTIFICATE OF DEATH

08010

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
c. LENGTH OF STAY IN lb <u>Lifetime</u>		d. STREET ADDRESS <u>142 N. Main Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>142 N. Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>E.</u> Last <u>Barr</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 2, 1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUST</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Barr</u>		14. MOTHER'S MARDEN NAME <u>Mary Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-5445</u>	
17. INFORMANT <u>Willard E. Barr, Perryville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Brachial Aneurysm</u> DUE TO (c) <u>109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>99</u> <u>109</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10</u> , 19 <u>57</u> , to <u>6-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-19</u> , 19 <u>62</u> , and that death occurred at <u>11:20</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>G. H. Richards Jr.</u>		22b. DATE SIGNED <u>6/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr. M.D.</u>		22d. ADDRESS <u>Port Deposit, Maryland.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-22-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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Volume 10

Figure 1

2004-2005

1. The first step is to identify the problem or question that needs to be answered.

Shawn Little, Editor

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08011

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martha Ellen Basham</b>		4. DATE OF DEATH <b>June 30 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-1879</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife Ret. Own Home</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>James Ridinger</b>		14. MOTHER'S MAIDEN NAME <b>Jane Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-54-3308</b>	
17. INFORMANT <b>Everett E. Basham</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyper-tension - Cerebrovascular disease</b> DUE TO (b) <b>Cerebral Sclerosis - C.V.A.</b> DUE TO (c) <b>Diabetic Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>24 hrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1948</b> , to <b>June 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1967</b> , and that death occurred at <b>7:20 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>G. H. Richards Jr.</b>		22b. DATE SIGNED <b>7/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. H. Richards Jr. M.D.</b>		22d. ADDRESS <b>Port Deposit Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-3-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Rising Sun Cecil Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. E. Miller</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James E. Young</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08026

## CERTIFICATE OF DEATH

08012

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN lb 35 Years		d. STREET ADDRESS 112 W. Main St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maude L Boyd		4. DATE OF DEATH Month Day Year June 24, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/1880
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Tyronne, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Marker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-2168	
17. INFORMANT Mr. Ralph Boyd (son)		Address 505 North Street Elkton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Acute Cardiac Failure DUE TO (b) Cardiac Myocarditis (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 18 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) the hospital attended the deceased from 12/13/1966 to 6/24/1967, that (I) last saw the deceased alive on 6/24/1967, and that death occurred on 3:30 PM, from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED June 26, 1967	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St. Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/28/67	23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cemetery, Cherry Hill, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Ralph E. Hicks		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Hicks Home for Funerals, Elkton, Md.		DATE JUN 30 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3502

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of other death.

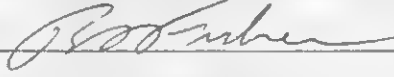

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08027

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08013

1 PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. LENGTH OF STAY IN Ia <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORTH EAST</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNION HOSPITAL</b>		d. STREET ADDRESS <b>Cecil Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>HERBERT RAYMOND BOYER</b>		4 DATE OF DEATH Month Day Year <b>6 7 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>3-14-23</b>
9 AGE (In years lost birthday) <b>44 yrs</b>		FUNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>No Info</b>	
14 MOTHER'S MAIDEN NAME <b>Alice M. Boyer</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW6 WW 2</b>	
16 SOCIAL SECURITY NO. <b>217-26-5053</b>		17 INFORMANT <b>Alice B. Weaver</b> Address <b>32 Rolling Mill Lane North East, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		22. DATE SIGNED <b>6-7-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>
23d. LOCATION (City or Town) (County) (State) <b>North East Cecil Md.</b>		25a. REC'D BY REGISTRAR <b>Paul R. Brown</b>	
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25b. REGISTRAR'S SIGNATURE 	

JUN 9 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far back papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

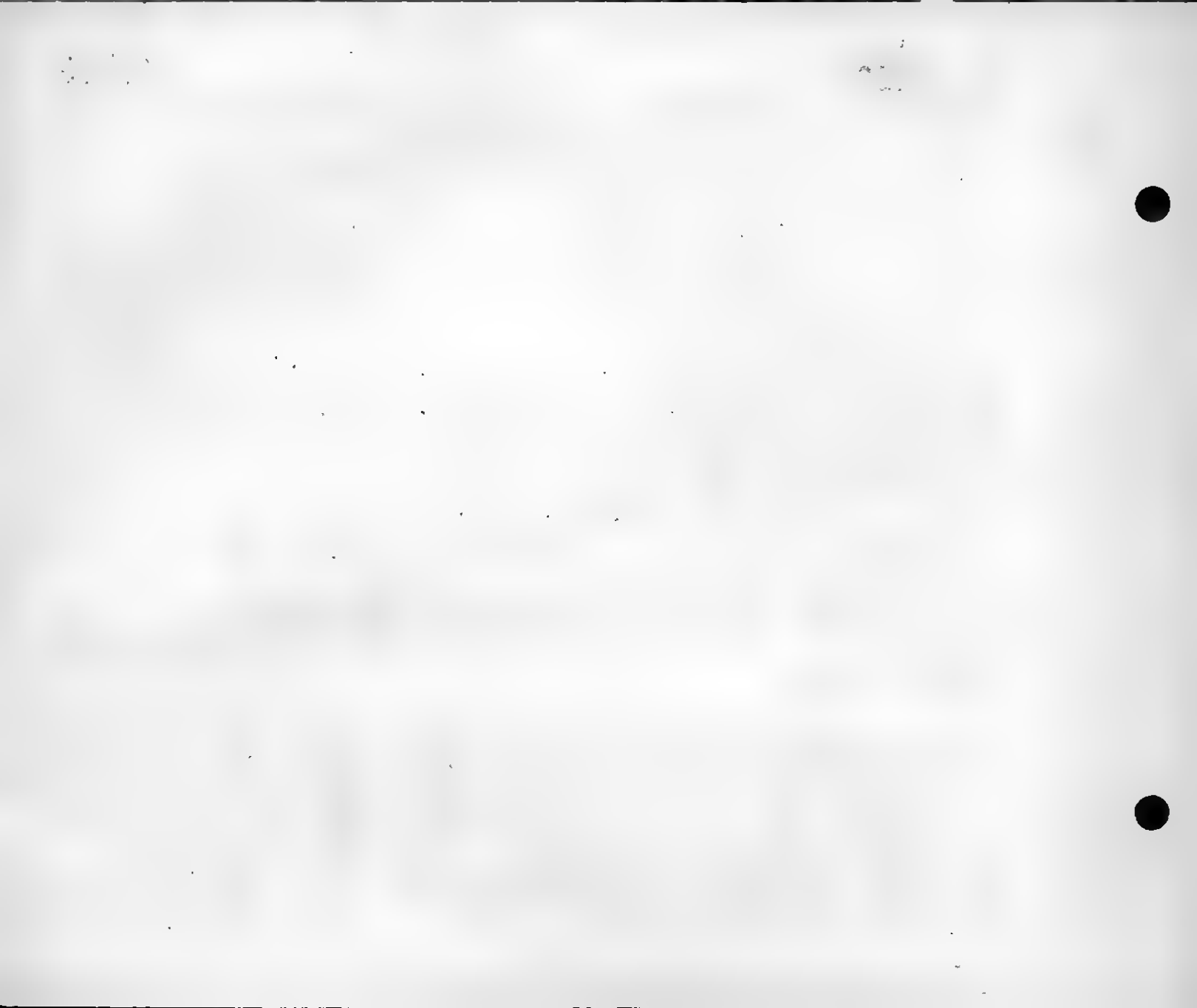
VR A15 (4)  
20 M 1/66

08028

CERTIFICATE OF DEATH

08014

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>BOHEMIA AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>AGNES MAY BROWN</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-8-03</u>	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CECIL MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES P. TATMAN, SR.</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE BUSKIRK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>FRANCIS P. BROWN</u> Address <u>CHESAPEAKE CITY MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Urinary tract infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ADRENAL FAILURE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/15, 1967</u> to <u>6/29, 1967</u> that (I) (we) last saw the deceased alive on <u>6/29, 1967</u> and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>I. R. Ross</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. R. ROSS, M.D.</u>				22d. ADDRESS <u>MEDICAL PARK, ELKTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESAPEAKE CITY CECIL MD</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME ELKTON, MD</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08029

08015

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 4 Yrs. 3 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pratt Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIAN MERRITT BROWN		4. DATE OF DEATH June 21 1967		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25 1890	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur M. Brown		14. MOTHER'S MAIDEN NAME Debroah L. Lambert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number or dates of service) No		16. SOCIAL SECURITY NO 214-14-8791		17. INFORMANT Margaret D. Brown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Uremia DUE TO 792X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. INTERVAL BETWEEN ONSET AND DEATH 20 yrs.		20. ADDRESS R.D. 1 Box 66 West Grove, Pa.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) North East		20g. (County) Cecil		20h. (State) Md.	
21. I certify that (this hospital) attended the deceased from 7-63 to 6-21 1967 that (we) last saw the deceased alive on 6-15 1967 and that death occurred at 10 PM, from the causes and on the date stated above.		22a. SIGNATURE Jay S. Barnhart Jr.		22b. DATE SIGNED 6/21/67	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.		22d. ADDRESS 4 Mauldin Ave.		22e. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/67		23c. NAME OF CEMETERY OR CREMATORY North East Methodist	
23d. LOCATION (City, town or county) North East		23e. REGISTRAR'S SIGNATURE		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE Grant Funeral Home		24b. ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR JUN 23 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

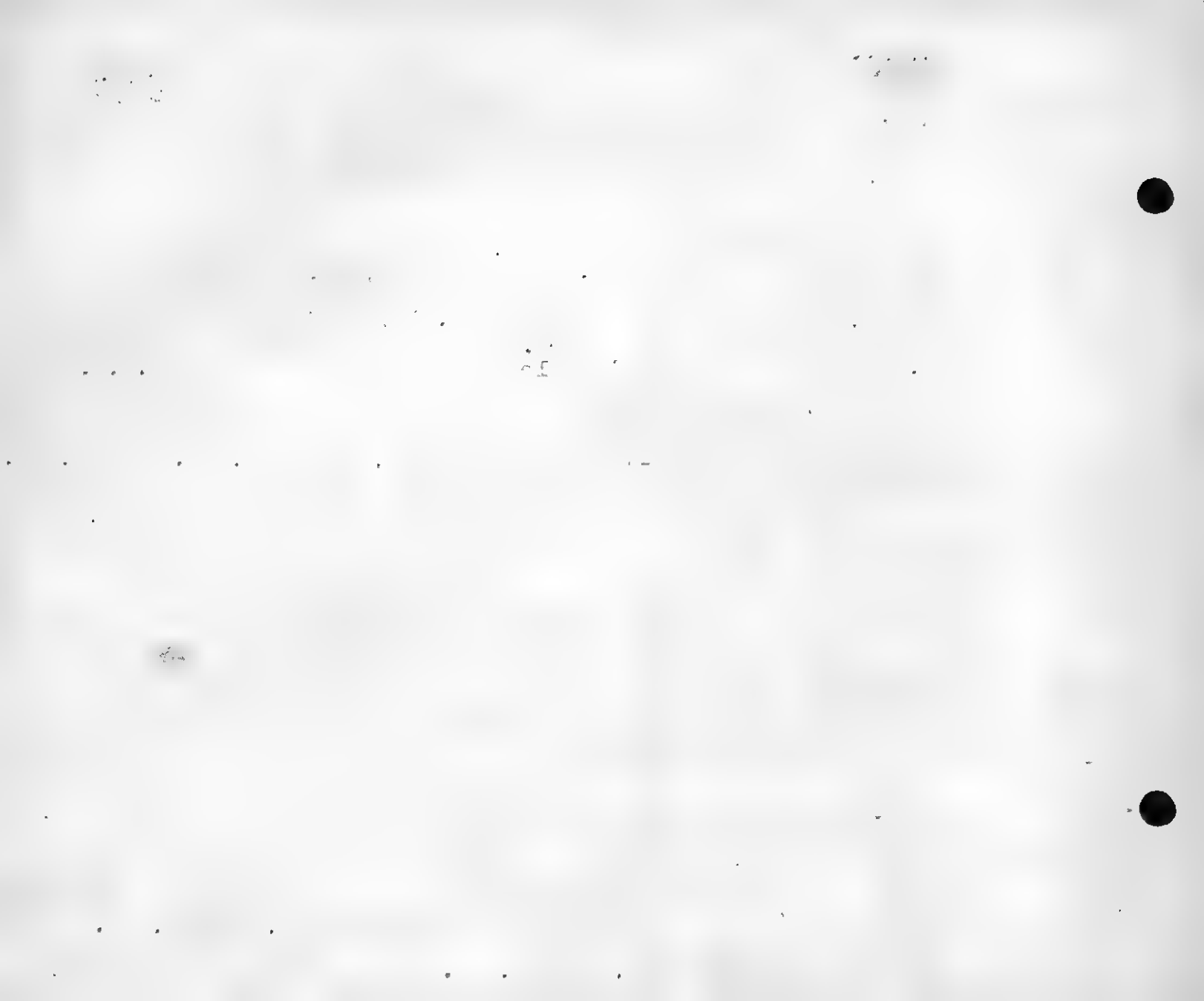
08030

# CERTIFICATE OF DEATH

08016

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Mills</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Kenneth E. Charshee</b>				4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1922</b>		9. AGE (In years last birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mach. Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Corp. General Cable</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Ernest Charshee</b>				14. MOTHER'S MAIDEN NAME <b>Edna Marie Wasserman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-16-4978</b>		17. INFORMANT <b>Kenneth E. Charshee, Jr. Elkton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA STOMACH</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/22</b> , 19 <b>67</b> , to <b>6/29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/29/67</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>John A. Fischer</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>6/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Fischer</b>				22d. ADDRESS <b>ELKTON, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/3/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Hicks Home for Funerals, Elkton, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08031

## CERTIFICATE OF DEATH

08017

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
c. LENGTH OF STAY IN lb <b>2- Days</b>		d. STREET ADDRESS <b>236 Locust Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital Of Cecil County</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Brenda Sue Cooper</b>		4. DATE OF DEATH Month Day Year <b>June 25 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1967</b>
9. AGE (In years lost birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland Cecil</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clark Nonee Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Beatrice June Conley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>----</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Mrs. Clark Cooper (Mother)</b>		Address <b>236 Locust Lane Elkton, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/23/1967</b> , to <b>6/25/1967</b> , that (I) (we) last saw the deceased alive on <b>6/25/1967</b> , and that death occurred at <b>5 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>James L. Johnson</b>		22b. DATE SIGNED <b>6/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James L. Johnson M.D.</b>		22d. ADDRESS <b>245 East High St. Elkton, Cecil Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Hicks Home for Funerals, Elkton, Md.</b>		25a. RECEIVED BY REGISTRAR <b>DATE 6/30/67</b>	
25b. REGISTRAR'S SIGNATURE <b>Hicks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

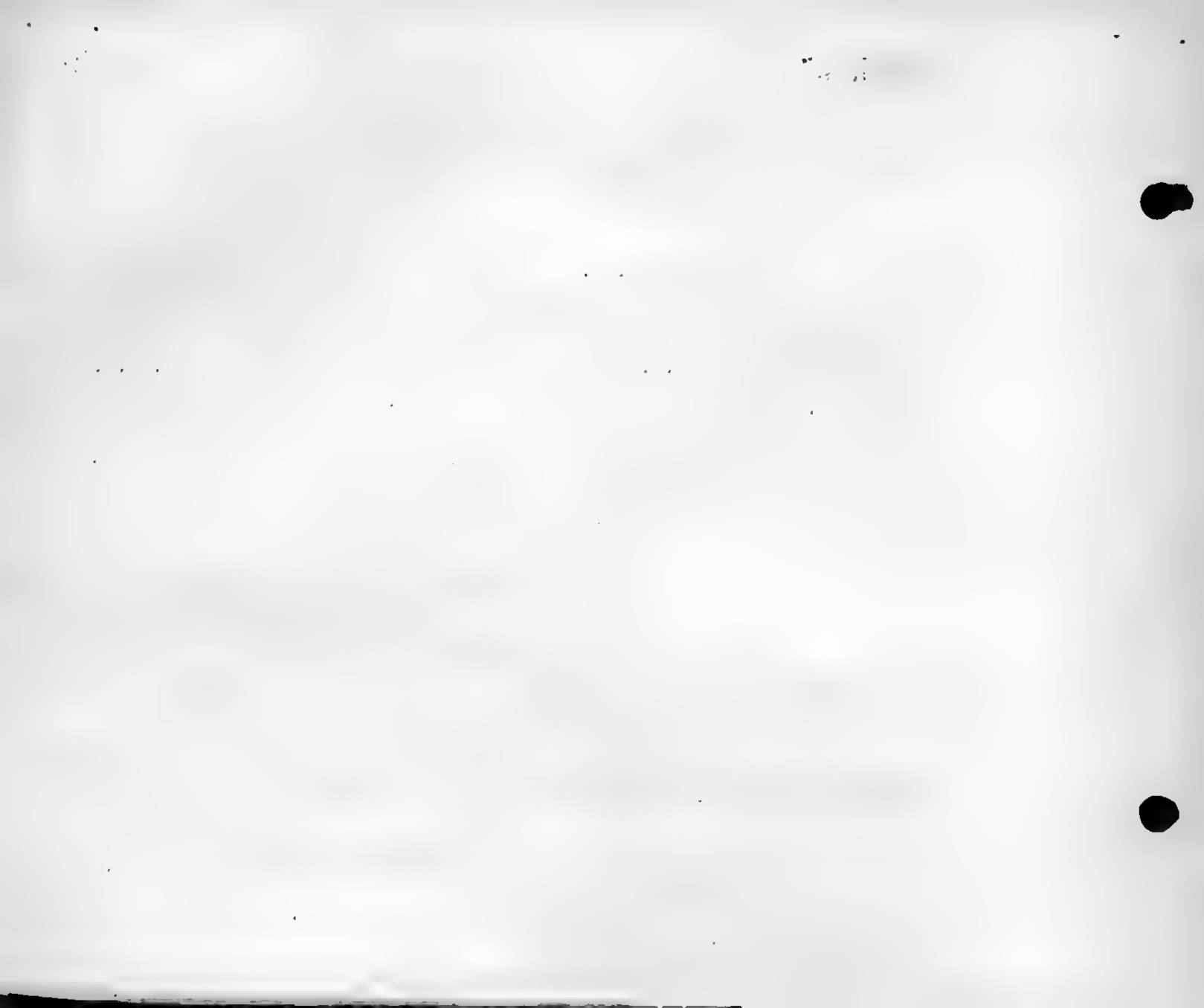
**08032**

**CERTIFICATE OF DEATH**

**08019**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>None</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>			c. LENGTH OF STAY IN lb <u>84 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VA Hospital</u>				d. STREET ADDRESS <u>319 Woodlawn Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edgar</u> Middle <u>A. C.</u> Last <u>Curran</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/90</u>		9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Officer (Retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Stephen H. Curran</u>				14. MOTHER'S MAIDEN NAME <u>Margaret O'Connor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>214-12-4504</u>		17. INFORMANT <u>VA Hospital Records, Perry Point, Md.</u>			Address
<b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (b) <u>With Myocardial Fibrosis</u> DUE TO <u>Arteriosclerosis, generalized</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>VA</u> 19 <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(VA Hospital)</u> attended the deceased from <u>March 25</u> , 19 <u>67</u> , to <u>June 17</u> , 19 <u>67</u> , and that death occurred at <u>6:45am</u> , from causes on and the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>6-17-67</u>		22c. PHYSICIAN'S NAME (Type) <u>S. GOLDGRABEN</u>	
22d. ADDRESS <u>VA Hospital, Perry Point, Md.</u>				22e. REC'D BY REGISTRAR DATE <u>JUN 26 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington VA</u>	
24. FUNERAL DIRECTOR <u>Patterson Funeral Home, Perryville, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)  
20 M 1/66

08033

CERTIFICATE OF DEATH

08020

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burgl, ELKTON</u>	
c. LENGTH OF STAY IN lb <u>1 hr. 31 min</u>		d. STREET ADDRESS <u>R.D. #5</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Flemo</u> First <u>Dameron</u> Middle <u>Ann</u> Last		4. DATE OF DEATH <u>June 16</u> Month <u>16</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1967</u>
9. AGE (In years lost birthday) <u>1</u> yrs <u>1</u> month <u>31</u> days <u>31</u> hours <u>31</u> min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cecil Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Flemo Dameron</u>	
14. MOTHER'S MAIDEN NAME <u>Sara Ann Simmons</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lawrence A. Simmons, North East Md</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - (approx 22 weeks gestation)</u> DUE TO (b) <u>1111</u> DUE TO (c) <u>Condiions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>6</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-14-1967</u> to <u>6-16-1967</u> , that (I) (we) lost saw the deceased alive on <u>6-16-1967</u> , and that death occurred at <u>5 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Tillman D. Johnson</u> M.D.		22b. DATE SIGNED <u>6-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson M.D.</u>		22d. ADDRESS <u>123 Singer Ave. Elkton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>	23d. LOCATION (City or Town) (County) (State) <u>ELKTON Cecil Md.</u>
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08034

CERTIFICATE OF DEATH

08021

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Rfd. 1</b>	
3 NAME OF DECEASED (Type or print) <b>EDWARD R. DINSMORE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-97</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	9 AGE (In years lost birthday) yrs. <b>70</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dinsmore</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hamburg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>217548376</b>	
17. INFORMANT <b>VA Records, VA Hospital, Perry Point, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease</b> DUE TO (b) <b>Pulmonary emphysema</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o</b> m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>4-6-</b> , 19 <b>60</b> , to <b>6-27-</b> , 19 <b>67</b> and that death occurred <b>at 1:15 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Stephen A. Hegedus</b>		22b. DATE SIGNED <b>6-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. A. HEGEDUS, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>6-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Washington Md</b>
24. FUNERAL DIRECTOR <b>William F. Bast &amp; Sons</b>		25. REC'D BY REGISTRAR <b>June 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any county is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08035.		08022									
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY <u>CECIL</u>				a. STATE <u>MARYLAND</u>				b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<u>CHESAPEAKE CITY</u>				<u>CHESAPEAKE CITY</u>							
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				<u>BIDDLEST</u>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First Middle Last				Month Day Year							
<u>MARY CATHERINE DIXON</u>				<u>6 - 19</u>				<u>1967</u>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<u>FEMALE</u>		<u>WHITE</u>		<u>WIDOWED</u>		<u>5/8/1907</u>		<u>60</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>				<u>AT HOME</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
<u>SAMUEL COMLY</u>				<u>MARY E. MOORE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
<u>No</u>				<u>220-50-3777</u>				<u>HERMAN DIXON</u> <u>CHESAPEAKE CITY, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: <u>GENERALIZED CARCINOMATOSIS</u>											
IMMEDIATE CAUSE (a) <u>155X</u> DUE TO <u>CARCINOMA OF COLON</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>3 YEARS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
				<u>DIED IN BED AT HOME</u> <u>SENT FROM DELAWARE TWO DAYS BEFORE DEATH</u>							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				(City or town) (County) (State)			
<u>9/19/67</u>				<u>AT HOME</u>				<u>CHESAPEAKE CITY MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Henry V. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6/19/67</u>			
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY			
<u>BURIAL</u>				<u>6-22-67</u>				<u>STILL POND CEMT</u>			
								22d. LOCATION (City, town, or county) (State)			
								<u>STILL POND MD.</u>			
23. FUNERAL DIRECTOR				ADDRESS				24a. REC'D BY REGISTRAR			
<u>Victor N. Kennedy</u>				<u>STILL POND, MD.</u>				DATE <u>JUN 23 1967</u>			
								24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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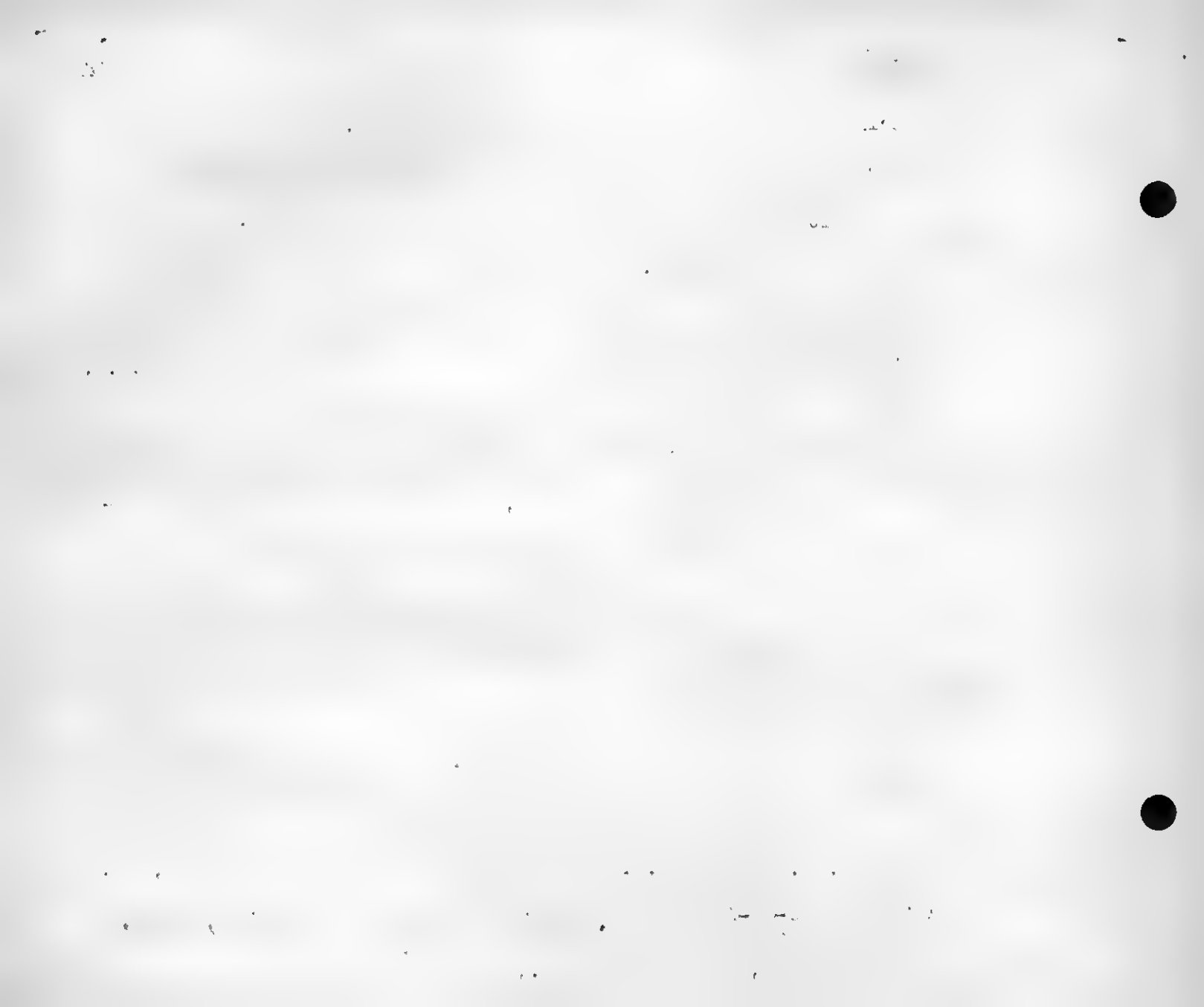
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08036

CERTIFICATE OF DEATH

08023

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Penna.</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>5 mos 9 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Maple East Apts B-27</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>				d. STREET ADDRESS <b>Horsham, Penna.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First <b>Thomss V.</b> Middle <b>Ely</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1967</b>				
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>6 22 14</b>		
9 AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Air Force</b>			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Pottsville, Pa.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry</b>				14. MOTHER'S MAIDEN NAME <b>Jennie McConon</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes Korean</b>		16 SOCIAL SECURITY NO. <b>176 32 45 04</b>		17 INFORMANT <b>VA Hospital - Perry Point, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO (b) <b>Chronic brain syndrome, cause unknown</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>4-7 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 13, 1967</b> to <b>June 21, 1967</b> , and that death occurred at <b>6:00 PM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>A. L. Mooney</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6-22-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>				22a. ADDRESS <b>VA Hospital, Perry Point, Md.</b>				
23a. BURIAL CREMATION <b>Buried</b>		23b. DATE THEREOF <b>6-28-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pottsville, Penna.</b>		
24. FUNERAL DIRECTOR <b>Lee Patterson Funeral Home</b>				25a. REC'D BY REG STRAR <b>JUN 28 1967</b>		25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>		



08037

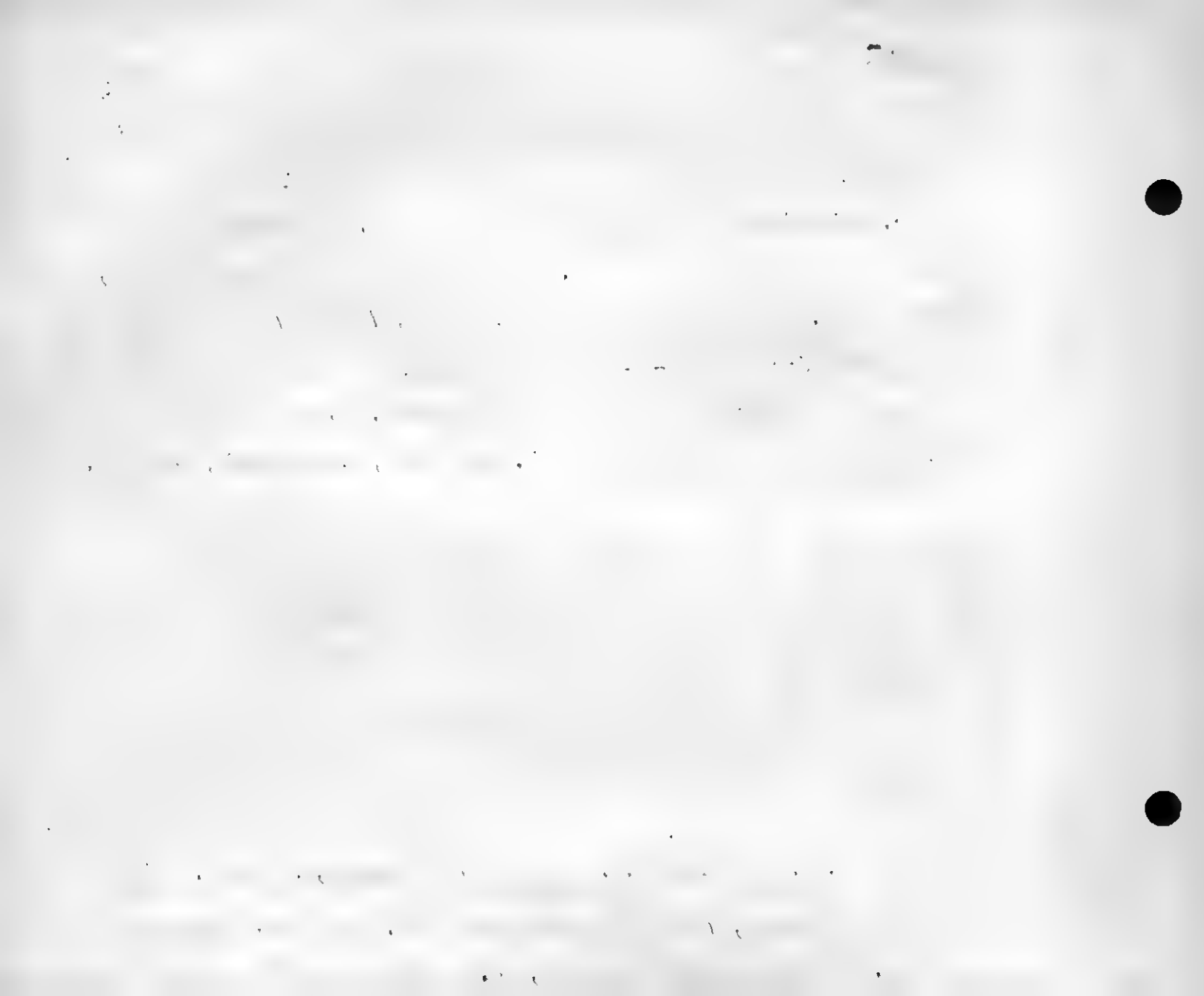
## CERTIFICATE OF DEATH

08024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm sion) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		c. LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>90 S. Main Street</i>		d STREET ADDRESS <i>90 S. Main Street</i>	
3 NAME OF DECEASED (Type or print) First <i>Olena</i> Middle <i>C.</i> Last <i>Fisher</i>		4. DATE OF DEATH Month <i>June</i> Day <i>27</i> Year <i>19 67</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>Cau.</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>March 21, 1876</i>
9 AGE (in years last birthday) <i>91</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (County & State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Caldwell</i>		14 MOTHER'S MAIDEN NAME <i>Sarah J. Brown</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO ---	
17 INFORMANT <i>W. Earl Fisher, Port Deposit, Maryland.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension, Cong. Vascular Disease</i> DUE TO (b) <i>Cerebral Vascular Accident</i> DUE TO (c) <i>12 hrs</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 10, 1965</i> to <i>6-27, 1967</i> that (I) (we) lost saw the deceased alive on <i>6-26, 1967</i> and that death occurred at <i>3:30 P.M.</i> from causes and on the date stated above.			
22a SIGNATURE <i>G. H. Richards Jr M.D.</i>		22b. DATE SIGNED <i>6/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. H. Richards Jr M.D.</i>		22d. ADDRESS <i>Port Deposit, Maryland. 21904</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>June 30, 1967</i>	23c NAME OF CEMETERY OR CREMATORY <i>West Nottingham Cem.</i>	23d LOCATION (City or Town) (County) (State) <i>Colona, Maryland</i>
24 FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>		25a REC'D BY REGISTRAR <i>JUL 10 1967</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08038

CERTIFICATE OF DEATH

08025

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admision) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN it <b>Kennedyville, Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>C. HARVEY FREEMAN</b> First Middle Last		4. DATE OF DEATH <b>JUNE 11 1967</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 1 - 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM B FREEMAN</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA WHITLOCK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>220-34-9550A</b>	
17. INFORMANT <b>HELP RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>CARCINOMA OF PROSTATE</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>3 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 1</b> , 1967, to <b>JUNE 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 10</b> , 1967, and that death occurred at <b>12:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Davis</b>		22b. DATE SIGNED <b>6/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS MD</b>		22d. ADDRESS <b>COTTESAPEAKE CITY MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 14, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Galena Cemetery.</b>	23d. LOCATION (City or Town) (County) (State) <b>Galena, Kent, Md.</b>
24. FUNERAL DIRECTOR <b>Edward Bellows, Mellington, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			





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VR A15 (4)  
20 M 1/66

08033

CERTIFICATE OF DEATH

08026

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>ELIZABETH</b> Last <b>GATEWOOD PATTERSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May, 6, 1906</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b> Hours <b>67</b> Min	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gilbert G. Edwards.</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Hughes.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>218-26-2203</b>	
17. INFORMANT <b>Son.</b>		Address <b>Cecilton, Md. 21913</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO (b) <b>Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic Glomerulonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/10</b> , 19 <b>67</b> , to <b>6/22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/22</b> , 19 <b>67</b> , and that death occurred at <b>10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Rolando A. Naser</b>		22b. DATE SIGNED <b>6/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROLANDO A. NASERA, M.D.</b>		22d. ADDRESS <b>105 E. MAIN ST. ELKTON, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial.</b>	23b. DATE THEREOF <b>June, 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cecilton, Cecil, Md.</b>
24. FUNERAL DIRECTOR <b>Edward Fellows &amp; Son,</b>		ADDRESS <b>Millington, Md. 21651</b>	
25a. REC'D BY REGISTRAR DATE <b>JUN 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



08040

## CERTIFICATE OF DEATH

08027

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. STREET ADDRESS <b>R.D. 1</b>	
3 NAME OF DECEASED (Type or print) <b>HARRIETT A. HAMBLETON</b>		4 DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 3, 1896</b>
9 AGE (In years last birthday) <b>70 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Caanan N.H.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fred B. Hill</b>		14 MOTHER'S MAIDEN NAME <b>Nora Evans</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or if unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Ernest J. Hambleton</b>		Address <b>R.D. 1 North East, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diabetes Mellitus - Metabolic Acidosis</b> 260x DUE TO (b) <b>Acute Myeloid Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>4 wks</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>5 June, 1967</b> , to <b>12 June, 1967</b> , that (II) (we) last saw the deceased alive on <b>12 June 1967</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Klaus H. Huebner</b>		22b DATE SIGNED <b>6/12/67</b>	
22c PHYSICIAN'S NAME (Type) <b>KLAUS H. HUEBNER</b>		22d ADDRESS <b>NORTH EAST, Md</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>6/15/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. Mary Anne's</b>	23d LOCATION (City or Town) (County) (State) <b>North East Cecil Md.</b>
24 FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a REC'D BY REGISTRAR <b>Box 22 North East, Md.</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c DATE <b>JUN 14 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08041

08028

PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>36 yrs 5 mos 6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY BYRNE HAMILL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/87</b>
9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Oakland (Garrett Co) Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gilmor S. Hamill (Deceased)</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>189-46-8860</b>	
17. INFORMANT <b>VA Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>31</b> , to <b>6/15</b> , 19 <b>67</b> , and that death occurred on <b>6/15</b> from causes and on the date stated above			
22a. SIGNATURE <b>B. ROTHELD, M.D.</b>		22b. DATE SIGNED <b>6/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. ROTHELD, M.D.</b>		22d. ADDRESS <b>VAH Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>6-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Jack Patterson &amp; Son, Perryville, Md</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>JUN 26 1967</b>	



08042

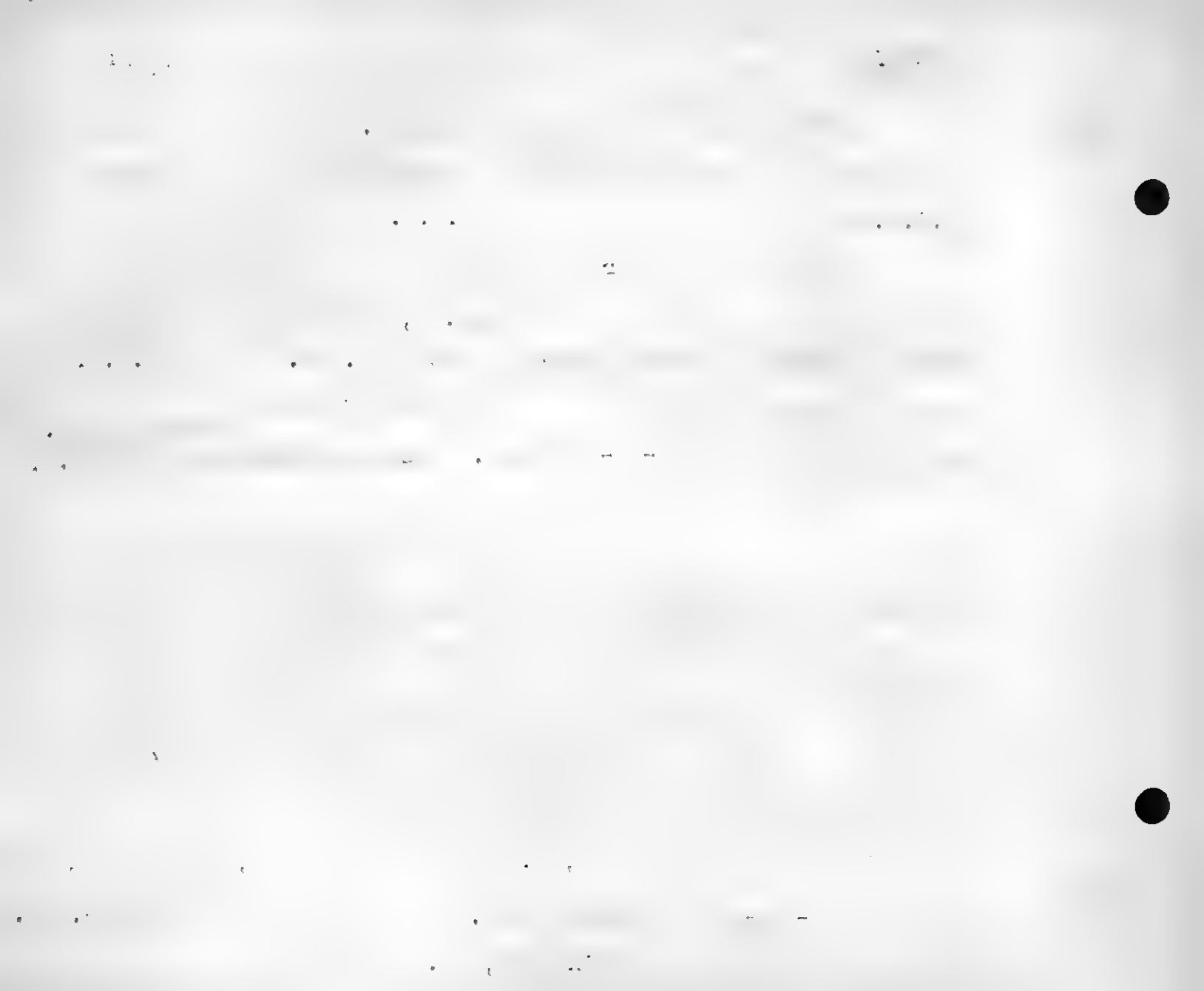
## CERTIFICATE OF DEATH

C8029

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Rural</b>	
c. LENGTH OF STAY IN TB <b>3 Weeks</b>		d. STREET ADDRESS <b>R.F.D. # 3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. # 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Henry Hargan</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1876</b>
9. AGE (in years lost birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bread Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bread Bakery</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Hargan</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Armstrong</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>194-22-8330</b>	
17. INFORMANT <b>Mrs. Elizabeth Stackhouse</b>		18. ADDRESS <b>618 South Ave. Bridgeton</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>ASCD</b> DUE TO (c) <b>lost</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-20-</b> , 19 <b>66</b> , to <b>6-3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-3</b> , 19 <b>67</b> and that death occurred at <b>5:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John J. Bannister, Jr.</b>		22b. DATE SIGNED <b>6-8-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John J. Bannister, Jr., M.D.</b>		22d. ADDRESS <b>301 W. Preston St., Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-10-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bayview Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Bayview Cecil Co. Md.</b>
24. FUNERAL DIRECTOR <b>Edmond M. Mullen</b>		25a. REC'D BY REGISTRAR <b>Rising Sun, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Bannister, Jr.</b>		25c. DATE <b>JUN 12 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

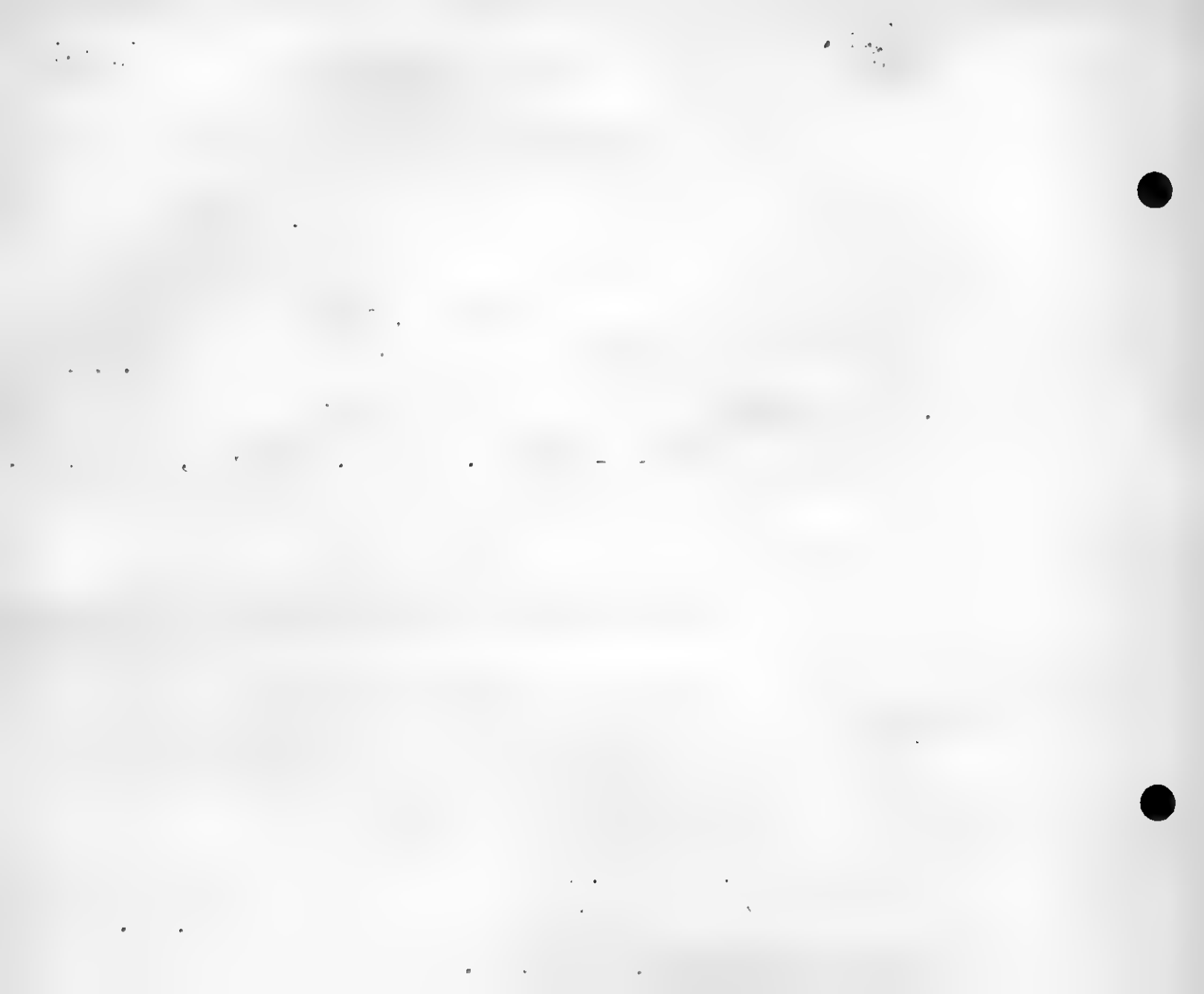
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08031

1 PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>Elkton</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNION HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> d. STREET ADDRESS <b>Box 174-B - Rt. #5, Elkton, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>CARVER FLETCHER HENDERSON</b>		4 DATE OF DEATH Month Day Year <b>6 25 19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 27, 1933</b>
9 AGE (in years lost birthday) <b>33 yrs</b>		FUNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>D. Lake Henderson</b>		14. MOTHER'S MAIDEN NAME <b>Nina Blevins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>264-58-4456</b>	
17. INFORMANT <b>Mrs. Nancy C. Henderson, Elkton, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Shot self through roof of mouth</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot self through roof of mouth</b>	
20c. TIME OF INJURY Month, Day, Year <b>6 25 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Wooded area</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>Pleasant Hill Cecil Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		22. DATE SIGNED <b>6-26-67</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Darlington Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Darlington, Md.</b>
24 FUNERAL DIRECTOR <b>Hicks Home for Funerals, Elkton, Md.</b>		25a. RECORDED BY REG. STAFF <b>DATE JUN 30 1967</b>	
25b. REG. STAFF'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08044

CERTIFICATE OF DEATH

08032

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>4990 Columbia Pike</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH HODGES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-93</b>
9. AGE (in years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>07</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military retiree</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, DC</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William M. Hodges</b>		14. MOTHER'S MAIDEN NAME <b>Julia Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes PL 28</b>		16. SOCIAL SECURITY NO. <b>224-54-3814</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable ventricular fibrillation,</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic heart disease, severe</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>June 14, 1967</b> to <b>June 30, 1967</b> , and that death occurred at <b>1:00 PM</b> on <b>June 30, 1967</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Agustin R. Garcia</b>		22b. DATE SIGNED <b>7-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. R. GARCIA</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-1-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR <b>C. M. Thayer</b>		25a. REC'D BY REG. STRAR <b>JUL 5 1967</b>	
MURPHY FUNERAL HOME 3524 Columbia Pike, Arlington, Va.		25b. REG. STRAR'S SIGNATURE <b>James Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 3 and 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M  
5M 1/43

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crothers Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura Bell Honaker</u>		4. DATE OF DEATH <u>6 16 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1907</u>
9. AGE (In years less birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dowell Hale</u>		14. MOTHER'S MAIDEN NAME <u>Laura Fletcher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-1678</u>	
17. INFORMANT <u>Jonas Honaker</u>		Address <u>Rising Sun Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>ARTERIOSCLEROTIC DISEASE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROTIC DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>INST.</u> <u>SEVERAL</u> <u>HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NO</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>6/16 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AT HOME</u>		20f. (City or town) <u>Rising Sun</u> (County) <u>CECIL</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-19-1967</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		22d. LOCATION (City, town, or county) <u>Port Deposit Md.</u>	
23. FUNERAL DIRECTOR <u>McMullen</u>		24a. REC'D BY REGISTRAR <u>JUN 19 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			



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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08046

CERTIFICATE OF DEATH

08033

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>	
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Lucille</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>6</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1914</b>
9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence Miller</b>		14. MOTHER'S MAIDEN NAME <b>Naomie Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>30-18-1945</b>	
17. INFORMANT <b>Mrs. Cecil Boddy</b>		Address <b>Conowingo Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>RENAL FAILURE</b> DUE TO (c) <b>CHRONIC GLOMERULONEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA, HYPERTENSIVE CARDIOVASCULAR DISEASE</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>1967</b> , that (I) (we) last saw the deceased alive on <b>5 June</b> <b>1967</b> , and that death occurred at <b>12:40 AM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Robert L. Gagar</b>		22b. DATE SIGNED <b>6 June 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Gagar</b>		22d. ADDRESS <b>ELKTON MEDICAL PARK ELKTON</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-10-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Zoar Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Conowingo Cecil Md.</b>	
24. FUNERAL DIRECTOR <b>H. M. Muller</b>		25a. REC'D BY REGISTRAR <b>Rising Sun, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Orlando Judge</b>		DATE <b>JUN 8 1967</b>	





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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08047

# CERTIFICATE OF DEATH

08034

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c LENGTH OF STAY IN 1b Life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Knight		4 DATE OF DEATH June 26 1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/30/1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Store Keeper		11. BIRTHPLACE (County & State, or foreign country) Cherry Hill Md.	
13. FATHER'S NAME Edwin Knight		14. MOTHER'S MAIDEN NAME Julia Ann Stern	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 213-05-6144	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4341 DUE TO Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3- Weeks	
(b) Pulmonary Edema		3- Days	
(c) Uremia		2- Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 4/14/1967 to 6/26/1967, that (I) (we) last saw the deceased alive on 6/26/1967, and that death occurred at 2:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson M.D.		22b. DATE SIGNED 6/26/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St. Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/29/67	23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem	23d. LOCATION (City or Town) (County) (State) Cherry Hill Cecil Md.
24 FUNERAL DIRECTOR H. Walter du Bose, Jr		25a. REC'D BY REGISTRAR DATE 11 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



08048

## CERTIFICATE OF DEATH

08035

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLESTOWN MANOR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION Hospital, EIKTON MD</u>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>George L. Koller</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 3, 1899</u>
9. AGE (In years lost birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George S. Koller</u>		14. MOTHER'S MAIDEN NAME <u>HETTIE BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>216-01-3721</u>	
17. INFORMANT <u>Mrs. MAUDE Koller</u>		Address <u>CATonsville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR FAILURE</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>PULMONARY EDEMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>6 days</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ERYTHROLEUKEMIA-ARTHERIOSCLEROSIS/A.S.C.V.D.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 24, 1967</u> , to <u>JUNE 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 15, 1967</u> , and that death occurred at <u>10:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Luis M. Cuza</u>		22b. DATE SIGNED <u>6-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUIS M. CUZA, M.D.</u> <u>322 E. Cecil Avenue</u> <u>North East, Md. 21901</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. COUNTY MD</u>
24. FUNERAL DIRECTOR <u>E. S. W. Nabb</u> <u>301 Frederick Rd</u> <u>BALTO MD</u>		25a. REC'D BY REGISTRAR <u>JUN 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08043

CERTIFICATE OF DEATH

08036

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Elkton</b>		c. LENGTH OF STAY IN IB <b>Lifelong days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>		d. STREET ADDRESS <b>R.D. 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Hasson Lynch</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 30, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Cecil County, Md.</b>
13. FATHER'S NAME <b>James Lynch</b>		14. MOTHER'S MAIDEN NAME <b>Ella Rebecca Tyson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-5363</b>	17. INFORMANT <b>Mrs. Paul Abrams</b> Address <b>Colora, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 473X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Pneumonia, Acute coronary.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>11 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1967</b> , to <b>June 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 4, 1967</b> , and that death occurred at <b>5 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>James L. Johnson</i>		22b. DATE SIGNED <b>June 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James L. Johnson</b>		22d. ADDRESS <b>245 East High St. Elkton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cecil Md.</b>
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Paul R. Crockett</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>JUN 7 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08050

08037

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>55 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Elkton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RD # 3</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN A. MAHALA</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-04</b>
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Watchman</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ashland, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Mahala (D)</b>		14. MOTHER'S MAIDEN NAME <b>Abby Ausburn (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>217-07-4044</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Congestive pulmonary edema, recurrent</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>May 5, 1967</b> , to <b>June 29, 1967</b> , and that death occurred at <b>1:00 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. L. MOONEY</b>		22b. DATE SIGNED <b>6-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>6-30-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mahala Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Creston, North Carolina.</b>
24. FUNERAL DIRECTOR <b>Patterson &amp; Son Funeral Home, Perryville, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08051

08038

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 16 <b>24 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>			d. STREET ADDRESS <b>100 Bow Street</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sadie G. McConnell</b>			4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1906</b>		9. AGE (In years last birthday) <b>60</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.M.R. Corp.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Ferguson</b>			14. MOTHER'S MAIDEN NAME <b>Pugh</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-38-2346</b>		17. INFORMANT <b>Warner J. Hamilton, Elkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery heart disease</b> 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Asthmatic bronchitis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>June 15</b>		20f. (City or town) (County) (State) <b>June 17 1967</b>
21. I certify that (I) (this hospital) attended the deceased from <b>June 15</b> , 19 <b>67</b> , to <b>June 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 17</b> , 19 <b>67</b> , and that death occurred at <b>11:15 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>S. Ralph Andrews, Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>		22d. ADDRESS <b>233 E. Main St., Elkton, Maryland</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Elkton, Md.</b>	
24. FUNERAL DIRECTOR <b>Hick's Home for Funerals, Elkton, Md.</b>		25a. REC'D BY REGISTRAR <b>June 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John B. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08052

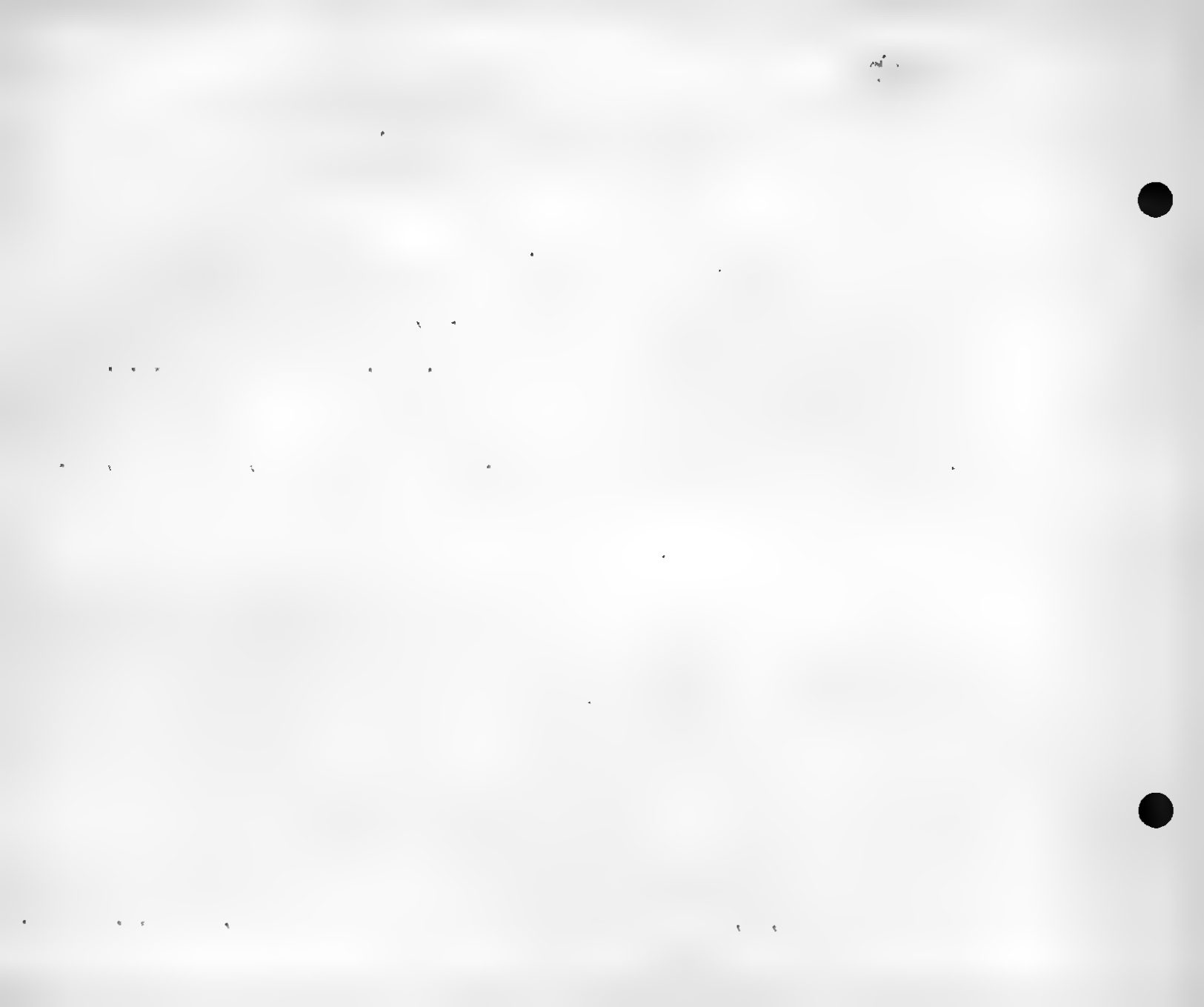
## CERTIFICATE OF DEATH

08039

1 PLACE OF DEATH a COUNTY <b>Cecil</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earleville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First Middle Last <b>McDOWELL</b>				4 DATE OF DEATH Month <b>6</b> Day <b>16</b> Year <b>1967</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 27, 1895</b>		9 AGE (In years last birthday) yrs. <b>71</b>	10 IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b> Hours <b>67</b> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Bricklayer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Mason</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Wilm. Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William McDowell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Irvin.</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>222-07-2014</b>		17 INFORMANT Address <b>Mrs. Freda Ruth McDowell, Earleville, Md.</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ROPTURE OF LEFT VENTRICLE</b> DUE TO <b>MYOCARDIAL INFARCT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>DROPPED OVER WHILE SITTING UP</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <b>UNION HOSPITAL</b>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6/11</b> , 19 <b>67</b> , to <b>6/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 16 1967</b> , and that death occurred at <b>6:15 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Edmund V. Davis MD</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <b>6/16/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>EDMUND V. DAVIS MD</b>		22d ADDRESS <b>UNION HOSPITAL, EARLEVILLE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>June, 19, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gracelawn Memorial Park</b>		23d LOCATION (City or Town) (County) (State) <b>Wilmington, N.C. Co; Del.</b>	
24 FUNERAL DIRECTOR <b>Edmund V. Davis MD</b>		ADDRESS <b>Wilmington, Md.</b>		25a REG'D BY REGISTRAR DATE <b>JUN 20 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08053

## CERTIFICATE OF DEATH

08040

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before adm ssion) a. STATE Delaware b. COUNTY N.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Newark	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 17 Keller Drive	
3. NAME OF DECEASED (Type or print) John E McMunn		4. DATE OF DEATH 6 17 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/08
9. AGE (In years lost birthday) 68 yrs		10. IF UNDER 1 year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tire	
11. BIRTHPLACE (County & State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McMunn		14. MOTHER'S MAIDEN NAME Jennie McMunn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 048-09-5057	
17. INFORMANT Emma N. McMunn		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion(sudden)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Heart disease</u> DUE TO (c) <u>H A H D</u>			INTERVAL BETWEEN ONSET AND DEATH 1 year ? 10 years?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 60 to 6/17 19 67, that (I) (we) last saw the deceased alive on 6/15 19 67, and that death occurred at 405 A.M. from causes and on the date stated above.			
22a. SIGNATURE Peter Stavrakis MD		22b. DATE SIGNED 6/17/67	
22c. PHYSICIAN'S NAME (Type) Peter Stavrakis MD		22d. ADDRESS Elkton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-20-67	23c. NAME OF CEMETERY OR CREMATORY Newark M. E. Cemetery	23d. LOCATION (City or Town) (County) (State) Newark N.C. Dela
24. FUNERAL DIRECTOR William J. Newark Dela		25a. REC'D BY REGISTRAR DATE JUN 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a permanent, within 72 hours after death.



08054

## CERTIFICATE OF DEATH

08041

1 PLACE OF DEATH a COUNTY <b>Cecil</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c LENGTH OF STAY IN 1b <b>Rock Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d STREET ADDRESS <b>xx</b>	
3 NAME OF DECEASED (Type or print) <b>William G. Mench</b>		4 DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 1, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Joseph Mench</b>		14. MOTHER'S MAIDEN NAME <b>Maryland Willis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>213-05-7287</b>	
17. INFORMANT <b>Maryland Pinder--Rock Hall, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 11/2/81 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1967</b> , to <b>June 2</b> , 1967, that (I) (we) last saw the deceased alive on <b>June 2</b> 1967, and that death occurred at <b>8:45 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>S. Ralph Andrews, Jr.</b>		22b. DATE SIGNED <b>June 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. RALPH ANDREWS, JR. M.D.</b>		22d. ADDRESS <b>233 E MAIN ST, ELKTON, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Burial</b>	23b. DATE THEREOF <b>June 5</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>	23d. LOCATION (City or Town) (County) (State) <b>Rock Hall, Maryland</b>
24. FUNERAL DIRECTOR. <b>Edgar L. Rane</b>		25a. REC'D BY REGISTRAR <b>JUN 9 1967</b>	
ADDRESS <b>Church Hill, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08055

CERTIFICATE OF DEATH

08042

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>47 Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital of Cecil County</b>		d. STREET ADDRESS <b>118 Clinton St.</b>	
3. NAME OF DECEASED (Type or print) <b>Ella First Reed Middle Moore Last</b>		4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/2/1889</b>
9. AGE (In years) <b>77</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Southall</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Jean Davis</b>		Address (Daughter) <b>#2 Vinsinger Lane, Elkton, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Central Pneumonia</b> DUE TO (b) <b>Cardiac Failure</b> DUE TO (c) <b>Myocarditis, Nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>4-Days</b> <b>3-Weeks</b> <b>2-Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/27/1967</b> to <b>6/19/1967</b> that (I) (we) last saw the deceased alive on <b>6/18/1967</b> , and that death occurred on <b>6/19/1967</b> , from causes on and on the date stated above.			
22a. SIGNATURE <i>James L. Johnson</i>		22b. DATE SIGNED <b>6/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James L. Johnson M.D.</b>		22d. ADDRESS <b>245 East High, St., Elkton, Cecil Md.</b>	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Burial</b>	23b. DATE THEREOF <b>June 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>	23d. LOCATION (City or Town) (County) (State) <b>Elkton Cecil Maryland</b>
24. FUNERAL DIRECTOR <i>Wm. B. Self</i>		25a. REC'D BY REGISTRAR <b>JUN 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



08056

## CERTIFICATE OF DEATH

08043

1 PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAESAREPPE CITY</b>	
c. LENGTH OF STAY IN 1b <b>18 DAYS</b>		d. STREET ADDRESS _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>JULIA ANN NOWLAND</b>		4. DATE OF DEATH <b>JUNE 29 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-10</b>
9. AGE (In years last birthday) <b>56</b> yrs		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET NURSES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RIDE HOSPITAL</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>CHRISTIANA DEL</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>RUBEN RHODES</b>		14 MOTHER'S MAIDEN NAME <b>IDA BUTLER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-05-0951</b>	
17. INFORMANT <b>ARNOLD F. NOWLAND</b>		Address <b>CHESAPEAKE CITY, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>DIABETES MELLITUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>SERIAL ATTACKS</b> DUE TO <b>SERIAL ATTACKS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SERIAL ATTACKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 25, 1965</b> to <b>JUNE 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Davis</b> M.D.		22b. DATE SIGNED <b>6/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS M.D.</b>		22d. ADDRESS <b>CHESAPEAKE CITY, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL</b>	23d. LOCATION (City or Town) (County) (State) <b>CHESAPEAKE CITY, MD.</b>
24 FUNERAL DIRECTOR <b>PONTIN FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>Robert Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Robert Judge</b>	
DATE <b>JUL 3 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08057

## CERTIFICATE OF DEATH

08044

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Roy Wesley Ragan</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Builder Contractor Cecil Co. Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry E. Ragan</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Hannah</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Mrs. Roy W. Ragan Colora, Md.</b>	
17. INFORMANT <b>Mrs. Roy W. Ragan Colora, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart - Sclerotic (Coronary) Disease</b> DUE TO (b) <b>Phlebotomy heart disease with stenosis</b> DUE TO (c) <b>Blood Clot Aorta</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>30 yrs</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-27</b> , 19 <b>61</b> , to <b>6-1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-1</b> , 19 <b>67</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>G. H. Richards Jr. M.D.</b>		22b. DATE SIGNED <b>6/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. H. Richards Jr. M.D.</b>		22d. ADDRESS <b>P.O. Box 1, Cecil</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-4-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Conowingo Baptist Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Conowingo Cecil Md.</b>
24. FUNERAL DIRECTOR <b>Norman McMillan</b>		25a. REC'D BY REGISTRAR <b>Dir. Tyson F. H. Rising Sun, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUN 5 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any other event, within 72 hours after death.

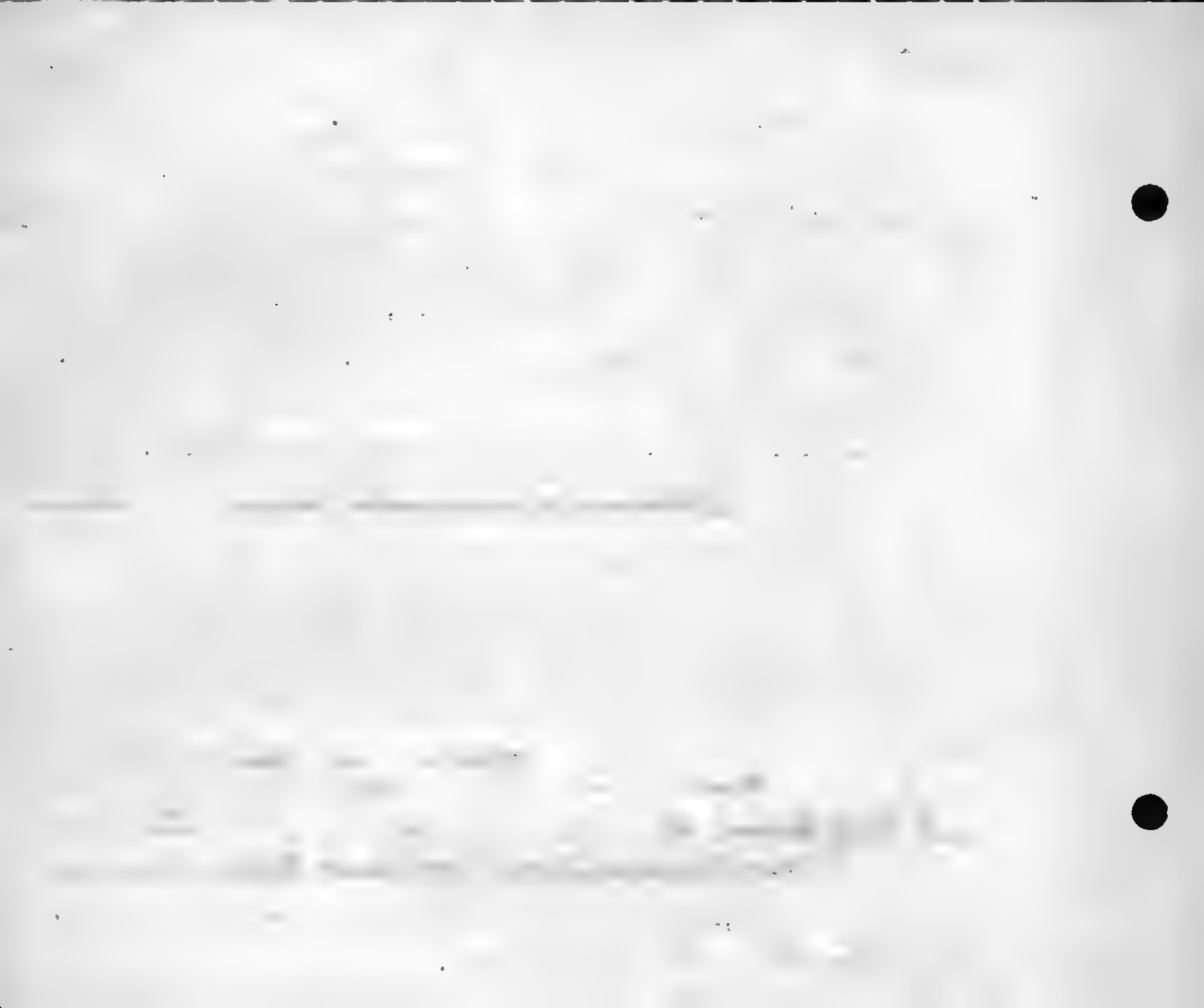


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08058					08045				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			R.D.#1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marietta Mearns Renn			4. DATE OF DEATH Month Day Year June 19 1967						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 16, 1877		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Abel James Mearns					14. MOTHER'S MAIDEN NAME Elizabeth Carter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-46-1090		17. INFORMANT Address James Renn North East, Md. R.D.#1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 7721 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 12, 1956, to June 19, 1967, that (I) (we) last saw the deceased alive on June 17, 1967, and that death occurred at 2 P.M. from the causes and on the date stated above.									
22a. SIGNATURE S. Ralph Andrews, Jr.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.			22b. DATE SIGNED June 19, 1967	
22c. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.					22d. ADDRESS 277 E. Main St. Elkton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		June 22, 1967		Rosebank Cemetery		Calvert Cecil Md.			
24. FUNERAL DIRECTOR Rising Sun, Md.					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

JUN 22 1967





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

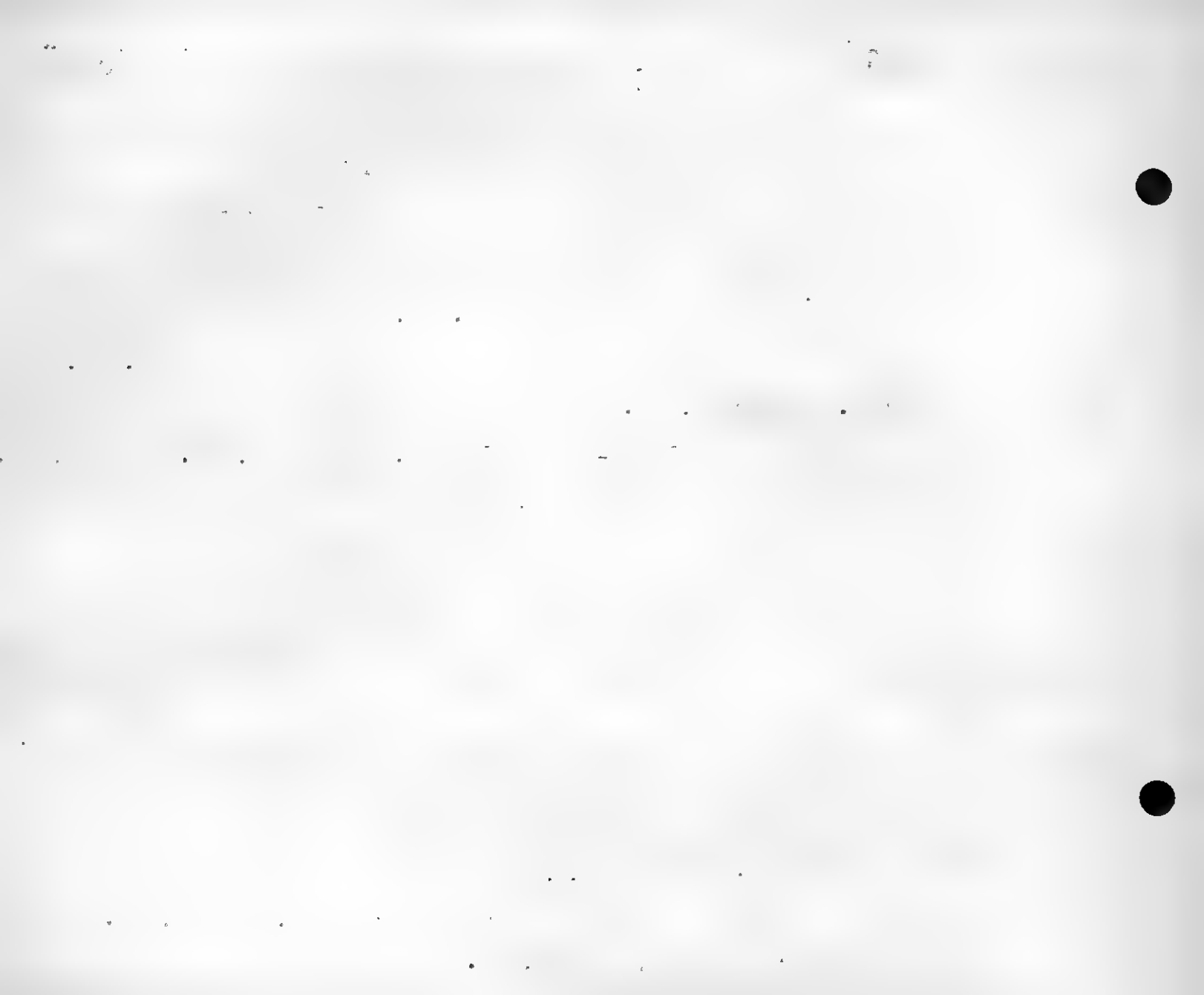
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08046

1 PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Landing Lane,</b>		d. STREET ADDRESS <b>285 Hollingsworth Manor</b>	
3 NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>EUGENE</b> Last <b>RINKERMAN</b>		4 DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 27, 1948</b>
9 AGE (in years lost birthday) <b>18</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemical Plant</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Chemical Plant</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Walter W. Rinkerman, Sr.</b>	
14 MOTHER'S MAIDEN NAME <b>Norma Creswell</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>213-52-7948</b>		17 INFORMANT <b>Walter W. Rinkerman, Sr. Elkton, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO (b) <b>929.8</b> (c) <b>Jumped out of burning boat and drowned</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Jumped out of burning boat and drowned</b>		
20c TIME OF INJURY Month Day Year Hour a.m. <b>6-17</b> 19 <b>67</b> p.m. <b>?</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>water</b>	20f (City or town) (County) (State) <b>Elk River, Elkton, Cecil Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>June 17, 1967</b>
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <i>Ralph E. Hicks</i> <b>Hicks Home for Funerals, Elkton, Md.</b>	25a REC'D BY REGISTRAR <b>JUN 23 1967</b>	25b REGISTRAR'S SIGNATURE <i>John J. Jones</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08060

CERTIFICATE OF DEATH

08047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Maryland</b> c. LENGTH OF STAY IN b <b>25 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VAH, Perry Point, Maryland</b>		d. STREET ADDRESS <b>3202 Ramona Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Stephen F. Rogan</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1890</b>
9. AGE (in years last birthday) yrs <b>77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Scranton, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Rogan</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>217-54-9835</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary congestion and edema acute</b> 4201 DUE TO (b) <b>Acute myocardial infarction due to ruptured</b> DUE TO (c) <b>atheroma of right coronary artery</b> Interval between onset and death <b>1 day</b> 30-60 Min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7:15</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) <del>has personally</del> attended the deceased from <b>11/5</b> , 1941, to <b>6/3</b> , 1967, and that death occurred at <b>6:15 p.m.</b> from causes on and on the date stated above			
22a. SIGNATURE <b>S. Goldgraben</b>		22b. DATE SIGNED <b>6-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN</b>		22d. ADDRESS <b>VAH, PERRY POINT, MARYLAND</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



08061

## CERTIFICATE OF DEATH

08048

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital of Cecil County</b>		d. STREET ADDRESS <b>Elkton</b>	
3 NAME OF DECEASED (Type or print) <b>Infant M. Gloria Walls</b>		4 DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1967</b>
9. AGE (In years lost birthday) yrs. <b>1</b> Months <b>1</b> Days <b>8</b> Hours <b>40</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cecil County, Md.</b>	
13. FATHER'S NAME <b>Edward L. Walls</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn New</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>213 Miller Corner Rd Edward L. Walls, Meadowview, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prematurity - App 25wks gestation</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-22-1967</b> , to <b>6-24-1967</b> , that (I) (we) last saw the deceased alive on <b>6-24-67</b> 19 <b>3:30</b> M, and that death occurred at <b>3:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>T. L. Johnson M.D.</b>		22b. DATE SIGNED <b>6-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. L. Johnson M.D.</b>		22d. ADDRESS <b>123 Singlerly Ave, Elkton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 24, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Elkton Cecil, Md.</b>
24. FUNERAL DIRECTOR <b>Richard E. Jackson R.R.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John E. Gage</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08064

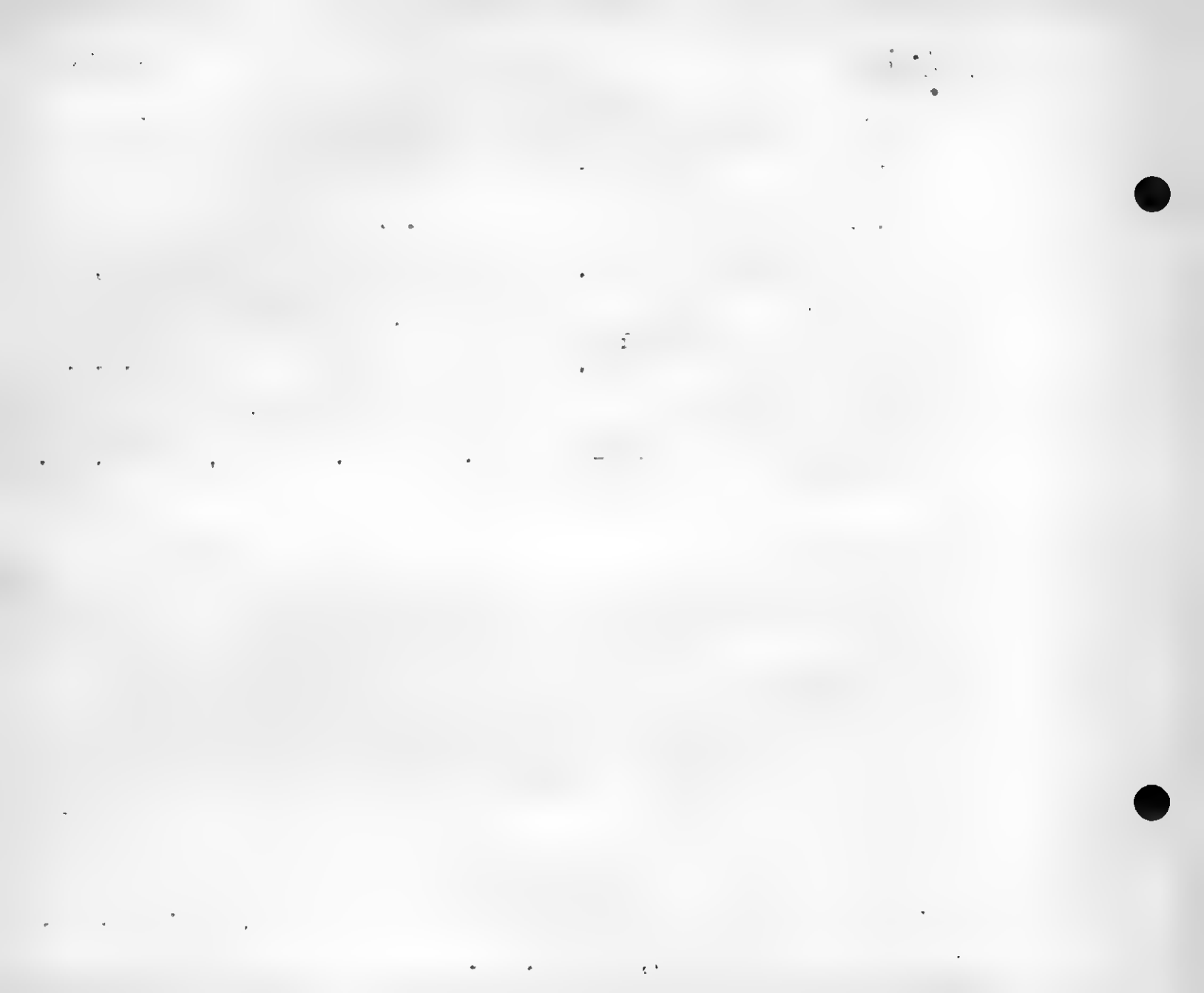
## CERTIFICATE OF DEATH

08049

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in this Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D. # 2</b>		d. STREET ADDRESS <b>R.D. # 2</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>William W. Walters</b>		4 DATE OF DEATH Month Day Year <b>June 16, 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR Months Days Hours <b>16, 19, 67</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Walters</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Goodyear</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-34-0570</b>	
17. INFORMANT Address <b>Mrs. Ethel W. Walters, Elkton, Md.</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Coronary artery Thrombosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>After 1 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan, 1966</b> , to <b>6-16, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6-16-1967</b> , and that death occurred at <b>10:29 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>T. Herman D. Sabasen M.D.</b>		22b. DATE SIGNED <b>6-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. Herman D. Sabasen M.D.</b>		22d. ADDRESS <b>103 Slingerly Ave. Elkton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Bethel Cecil Co. Md.</b>
24. FUNERAL DIRECTOR <b>Hicks Home For Funerals, Elkton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 23 1967</b>	25b. REGISTRAR'S SIGNATURE <b>R. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

08062

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08050

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CECIL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> c. LENGTH OF STAY IN b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL ELKTON MD</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> f. COUNTY <u>CECIL</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u> h. STREET ADDRESS <u>CHESAPEAKE CITY</u>		i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Samuel G. Warrick</u>		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>14</u> Year <u>1967</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>March 11, 1900</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>Henry Warrick</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella Moore</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>212-09-7730</u>		<b>17. INFORMANT</b> <u>Estella Warrick-Chesapeake City, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF BLADDER</u> DUE TO (b) <u>CARCINOMA OF BLADDER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)					
<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> (this hospital) attended the deceased from <u>JAN 16, 1967</u> to <u>JUNE 14, 1967</u> that (I) (we) last saw the deceased alive on <u>JAN 14, 1967</u> and that death occurred <u>5 PM</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Henry V. Davis</u> M.D.					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>HENRY V. DAVIS MD</u>					
<b>22b. DATE SIGNED</b> <u>6/16/67</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>6/18/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bohemia Manor, Cem.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Colin R. Beale</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Bohemia Manor, Md.</u>		<b>25. REC'D BY REGISTRAR</b> <u>JUN 19 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. ADDRESS</b> <u>909 Poplar St.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

08051

08063

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN lb <b>39 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>524 Randolph Street, NW</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WASHINGTON, Willis Rollins</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 67</b>	
SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/21</b>
9. AGE (In years last birthday) <b>46</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stafford County, Va.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Siman Washington (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Nora Brown (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO <b>230-01-0429</b>	
17. INFORMANT <b>VA Records, VAH Perry Point, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema and bronchopneumonia</b> DUE TO (b) <b>Scleroderma</b> DUE TO (c) <b>7/10.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>9-12 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>May 15, 19 67</b> , to <b>June 23, 1967</b> , and that death occurred at <b>5:00 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. L. Monney</b>		22b. DATE SIGNED <b>6/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MONNEY, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md. 21902</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Fredericksburg, Virginia</b>
24. FUNERAL DIRECTOR <b>KAY FUNERAL HOME, 1131 Charles Street, Fredericksburg, Va.</b>		25a. RECEIVED BY REGISTRAR DATE <b>JUN 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



38065

## CERTIFICATE OF DEATH

08052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fikton</b>		c. LENGTH OF STAY IN 1b <b>68 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Warrick (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>			d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CLIFTON R. WATERS</b>			4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1899</b>		9. AGE (In years last birthday) <b>68</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY  		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO <b>218-05-7560</b>		
17. INFORMANT <b>Clifton E. Waters - Warrick Md.</b>			Address  		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, ACUTE</b> DUE TO <b>1201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INCARCERATED inguinal hernia</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <b>6/23</b> , 19 <b>67</b> , to <b>6/23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/23/67</b> 19 <b>67</b> , and that death occurred at <b>1:00 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>John A. Fischer</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Fischer</b>		22d. ADDRESS <b>ELKTON, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bohemia Manor Cem.</b>	
23d. LOCATION (City or Town) _____ (County) _____ (State) _____		23e. LOCATION (City or Town) _____ (County) _____ (State) _____			
24. FUNERAL DIRECTOR <b>Robert Bell</b>		ADDRESS <b>909 Poplar St.</b>		25a. REC'D BY REGISTRAR <b>June 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



08066

## CERTIFICATE OF DEATH

08053

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>52 days</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA HOSPITAL, Perry Point, Md.</b>				d. STREET ADDRESS <b>2131 Massachusetts Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>Leo</b>		First <b>Ferdinand</b>		Middle <b>Williams</b>	
4 DATE OF DEATH <b>June 11, 1967</b>		Month <b>June</b>		Day <b>11</b>	
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <b>10-28-89</b>		9. AGE (in years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Estate caretaker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>St. Joseph, Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Eldier Williams</b>		14. MOTHER'S MAIDEN NAME <b>Molly Tymon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>577-42-8954</b>		17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive Emphysema, - Severe</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>4800</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (1) <del>XXXXXX</del> attended the deceased from <b>April 21, 1967</b> , to <b>June 11, 1967</b> , <del>XXXXXX</del> and that death occurred at <b>4:30am</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>B. Rothfeld</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. Rothfeld. M.D.</b>		22d. ADDRESS <b>VAH., Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-19-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery Washington, D.C.</b>	
23d. LOCATION (City or Town) <b>Washington, D.C.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Gawlers Sons Inc.</b>		ADDRESS <b>GAWLERS FUNERAL HOME, Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JUN 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





08067

## CERTIFICATE OF DEATH

08054

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ELKTON</u>	
c. LENGTH OF STAY in lb <u>LIFE</u>		d. STREET ADDRESS <u>RT. 7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT. 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary A Williams</u>		4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1888</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ELKTON, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VITO GALLO</u>		14. MOTHER'S MAIDEN NAME <u>NO INFO.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. ELIZABETH M. HEARY</u>		Address <u>CHARLESTOWN MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Breast Cancer + Melanoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 wk</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 1960, to <u>June 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 21</u> , 1967, and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph G. Lanzi</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6/22/67</u>
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH G. LANZI</u>		22d. ADDRESS <u>ELKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION</u>	23d. LOCATION (City or Town) (County) (State) <u>CHERRY HILL, CECIL MD.</u>
24. FUNERAL DIRECTOR <u>Robert J. Laund</u> ADDRESS <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ELKTON, MD</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1900

OFFICE OF THE ATTORNEY GENERAL

1900



08068

## CERTIFICATE OF DEATH

08055

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
c. LENGTH OF STAY IN lb <u>12 DAYS</u>		d. STREET ADDRESS <u>RD #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael Williams</u>		4. DATE OF DEATH <u>JUNE 30 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 15, 1880</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PENNA R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAR REPAIR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No INFO</u>		14. MOTHER'S MAIDEN NAME <u>No INFO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-01-624X</u>	
17. INFORMANT <u>MRS ELIZABETH HEAVY</u>		Address <u>CHARLESTOWN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Carcinoma of Lung</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>  </u> <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>May 1955</u> , to <u>June 30, 1957</u> , that (I) (we) last saw the deceased alive on <u>June 30 1967</u> , and that death occurred at <u>12:30 A.M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>Joseph G. Lanzi</u>		22b. DATE SIGNED <u>7/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH G LANZI</u>		22d. ADDRESS <u>MEDICAL PARK, ELKTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION</u>		23d. LOCATION (City or Town) (County) (State) <u>CHERRY HILL MD</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 5 1967</u>	

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22030

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